COUNTY OF LAKE
LCDSA-Unit 16 Insurance Rates 2020

Monthly Insurance Premuim Rates - 2020

	Active Rate per $1,000	Retiree Rate per $1,000	Dependent Life Rate per $1,000	Basic AD&D Rate per $1,000
Voya Life/AD&D	$0.181	$0.206	$0.386	$0.027

Basic Life Insurance is paid by the County.

LCDSA
Health, Dental, Vision, Group Life

	Employee Only	Employee +1	Employee +2 or more
Delta Dental	$38.70	$70.90	$118.10

	Employee Only	Employee +1	Employee +2 or more
VSP Vision	$6.66	$14.39	$23.81

	PERS Select			PERS Choice			PERS Care			PORAC (Members Only)		
	Emp Only	Emp +1	Emp + 2	Emp Only	Emp +1	Emp +2	Emp Only	Emp +1	Emp +2	Emp Only	Emp +1	Emp +2
Health Premium	$520.29	$1,040.58	$1,352.75	$861.18	$1,722.36	$2,239.07	$1,133.14	$2,266.28	$2,946.16	$774.00	$1,699.00	$2,199.00

Employee Selection for Benefits **Effective on (date) Jan 1, 2020**

(Circle) The selection below **is / is not** a change from my current coverage selection.

Note: Employees who do not Opt Out must select a minimum of Employee Only coverage for Health, Dental, Vision, and Life.

SELECTION (check box) **MONTHLY PAYROLL DEDUCTIONS / CONTRIBUTIONS**

Opt Out ☐ Proof of current employer sponsored group insurance coverage is attached — OPT OUT contribution is **$200**

County-Paid Life Insurance

	Employee Only	Employee + 1 or more	
County - ING Life Insurance	☐	☐	If Opting Out select Employee Only life insurance here

Section 125 (Cafeteria) Plan

	Employee Only	Employee +1	Employee + 2 or more	
Delta Dental Insurance	☐	☐	☐	Premium $
VSP Vision Insurance	☐	☐	☐	Premium $
Health Insurance	☐	☐	☐	Premium $

Write Health Plan name here

Premium SUBTOTAL $

*County Section 125 Contribution - $ Enter 80% of SUBTOTAL here

Total Monthly Cost to Employee $

The above reflects the current County contribution and payroll deduction, if applicable, for my selection of benefits. **I understand that rates are subject to change at renewal and the County Contribution is defined in the applicable MOU/Resolution and that any changes may affect my future payroll deductions.**

Print Employee Name: **Social Security #:**

Employee Signature: **Date:**

*In addition to the County Contribution, the County pays the full Health administration fee for active employees. Premium rates lised on the selection form are subject to change.

The employee has received copies of the Notice About The Early Retiree Reinsurance Program addressed to the employee and all dependents enrolled in the health plan.

HR Use Only

Amounts Verified ☐
Data Input Complete ☐
ERRP Notice ☐
By:
Date:
Comments to Payroll: